



MINUTES

Emergency Medical Services Study Committee

November 6-7, 2013

MEMBERS PRESENT:

Senator Mary Jo Wilhelm, Co-chairperson
Senator Michael Breitbach
Senator Jake Chapman
Senator Steven J. Soddors
Senator Rich Taylor

Representative Ralph C. Watts, Co-chairperson
Representative Bobby Kaufmann
Representative Todd Prichard
Representative Sandy Salmon
Representative Art Staed

MEETING IN BRIEF

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- I. Procedural Business
- II. Bureau of Emergency Medical Services, Iowa Department of Public Health
- III. Iowa Emergency Medical Services Association
- IV. Emergency Medical Services Training Programs
- V. Emergency Medical Services Reimbursement
- VI. Public Comment and Committee Discussion, November 6, 2013
- VII. EMS Provider Perspective
- VIII. EMS Advisory Council, Quality Assurance, Standards and Protocols Subcommittee
- IX. Public Comment and Committee Discussion, November 7, 2013
- X. Materials Filed With the Legislative Services Agency



Emergency Medical Services Study Committee

I. Procedural Business

Call to Order. The Emergency Medical Services Study Committee (committee) was called to order at 10:01 a.m. on November 6, 2013, in Room 116 of the State Capitol.

Committee Rules and Election of Co-chairpersons. The committee adopted the committee's rules of procedure and elected Senator Mary Jo Wilhelm and Representative Ralph Watts to be co-chairpersons of the committee.

Adjournment. Upon conclusion of the presentations and discussion by the committee on November 6, 2013, the meeting was adjourned at 2:49 p.m.

Call to Order. The committee reconvened at 10:01 a.m. on November 7, 2013, in Room 116 of the State Capitol.

Adjournment. Upon conclusion of the presentations and discussion by the committee on November 7, 2013, the meeting was adjourned at 12:28 p.m.

II. Bureau of Emergency Medical Services, Iowa Department of Public Health

Mr. Ken Sharp, Division Director for Acute Disease Prevention, Emergency Response, and Environmental Health, Ms. Rebecca Curtiss, Interim Emergency Medical Services (EMS) Bureau Chief, and Mr. Joe Ferrell, EMS Regulations Manager, provided an overview of the EMS Bureau structure and role in regulating EMS throughout the state.

Ms. Curtiss discussed the recent reorganization within the Iowa Department of Public Health (department), including a reorganization of the EMS Bureau. Ms. Curtiss was named interim bureau chief on September 23, 2013. Following the reorganization, the EMS Bureau consists of 11 full-time staff, of which 5.5 are funded through state resources. The additional 5.5 positions are funded through other sources, primarily federal grants. Ms. Curtiss outlined the EMS Bureau's areas of responsibility for coordinating and implementing the provision of emergency medical services in this state.

Ms. Curtiss discussed the EMS Bureau's staffing and budget reductions that have occurred over the past five years. During that time, the EMS Bureau's staffing level has been reduced by 3.3 employees and the EMS Bureau currently employs only one clerical staff person. The number of regional coordinators has been reduced from six to four. Mr. Ferrell identified short-term delays in inspections as one consequence of the reduction in regional coordinators. The EMS Bureau's current operating budget, excluding the Emergency Medical Services System Development Grants Fund is \$1.2 million. The EMS Bureau is no longer receiving funding from the Tobacco Settlement Fund and funding from federal grants has also decreased during that time. Ms. Curtiss also discussed the EMS Bureau's ongoing expenses relating to the maintenance of computer software packages and the bureau's efforts to move some computer support services to the Department of Administrative Services.

Mr. Ferrell provided an overview of the EMS Bureau's duties relating to the authorization and regulation of emergency medical service programs, the certification of emergency medical care providers, and the operation of training programs. Currently, the EMS Bureau is responsible for



such activities for the 17 training centers, 781 authorized EMS agencies, and approximately 12,000 individual EMS providers in Iowa. Information was presented to the committee detailing the types of and requirements for authorization of EMS service programs. Authorization is required to establish a service program using certified emergency medical care providers for the delivery of care at the scene of an emergency or nonemergency, during transportation to a hospital, during transfer from one medical care facility to another or to a private home, or while in the hospital emergency department and until care is directly assumed by a physician or by authorized hospital personnel.

An overview of the new levels of certification for individual EMS providers was presented, including Iowa's recent adoption of the National Registry of Emergency Medical Technicians (NREMT) practical and cognitive examinations. Mr. Ferrell also provided information relating to how the continuing education requirements for biennial renewal of a provider's certification vary based on the level of certification.

The duties of the EMS Bureau's regional coordinators were discussed. The bureau's representatives stressed the importance of the regional coordinators' work in conducting on-site periodic inspections, providing follow-up and guidance for EMS agencies, and performing other duties relating to compliance. The EMS Bureau also has duties undertaken by a program planner relating to the Iowa Statewide Emergency Registry for Volunteers.

The bureau's representative also described the bureau's role in administering the Emergency Medical Services System Development Grants Fund, which consists of moneys appropriated by the General Assembly and other moneys available from federal or private sources. Moneys in the fund are to be used to match, on a dollar-for-dollar basis, moneys spent by a county for the acquisition of equipment for the provision of EMS and to provide grants to counties for education and training in the delivery of EMS. A list of grant amounts by county over the three previous fiscal years was distributed to the committee.

Mr. Ferrell also discussed the composition, structure, and role of the Emergency Medical Services Advisory Council (EMSAC). Mr. Ferrell discussed how the bureau has engaged and worked with the Council in recent years, including during the bureau's revisions of its administrative rules relating to scope of practice.

Members of the committee questioned the continued efficiency of the EMS Bureau following the funding and staffing cuts over the past five years. Mr. Sharp indicated that conclusions regarding the continued efficacy of the EMS Bureau could not yet be reached and that a continued review of the bureau's operations was needed.

Mr. Sharp further discussed the need to determine the EMS Bureau's role in addressing issues in the EMS industry in the future.

EMS Bureau representatives also responded to questions from the committee relating to the cost of provider certification and to what extent such costs are causing a shortage in providers, the recent modifications to scope of practice rules, and the methods of providing and approving training and continuing education. In responding to committee questions relating to the EMS Bureau's process for addressing complaints and deficiencies involving providers and services, Mr. Ferrell stated that disciplinary processes across states vary greatly and he estimated that the



Emergency Medical Services Study Committee

bureau addresses between 250 and 375 deficiency and complaint reports annually. Members of the committee also raised concerns and requested additional information relating to the data reporting requirements and run sheet collection activities of the EMS Bureau.

III. Iowa Emergency Medical Services Association

Mr. Jerry Ewers, President, and Ms. Linda Frederiksen, Vice President, from the Iowa Emergency Medical Services Association (IEMSA), provided background information on IEMSA and how EMS is provided in Iowa. Additionally, the results of an EMS provider survey were presented to the committee. The survey resulted in approximately 900 responses.

Founded in 1987, IEMSA has been actively involved in emergency medical care in Iowa. IEMSA represents 12,000 EMS providers and has a 23-member board of directors. The Iowa EMS Association has been involved in initiating and supporting EMS legislation, representing its members on task forces, advisory groups, and boards, addressing issues that affect EMS services through service director meetings and educational programs, and facilitating communication between members.

In Iowa, EMS is delivered via a variety of types of service programs including volunteer, career, hospital-based, fire-based, third-service, private, and governmental. According to data provided by the EMS Bureau, 57 percent of EMS is provided through fire departments, 16 percent is provided by private companies, 13 percent is provided through hospital services, and 14 percent is provided by public entities. In Iowa, 64 percent of EMS providers are volunteers.

IEMSA conducted a survey of EMS providers and presented the results to the committee. The data collected included the type of EMS delivery model under which the provider works or volunteers, the number of EMS agencies for which the provider works or volunteers, the education background of the provider, the age of the provider, and the number of years that the provider has been an EMS provider. IEMSA also provided a map detailing the regions of the state where the survey respondents were located.

IEMSA's survey also focused on the attitudes and concerns of EMS providers. Staffing, recruitment, and retention of EMS providers, EMS not being considered an essential service, and inadequate funding were identified most often as concerns among the survey respondents. Respondents most often identified burnout, unreasonable time commitment, and wage and benefit concerns as the reasons for allowing EMS certification to lapse. Respondents were also asked to identify the most difficult times of day for providing EMS coverage and the number of hours per day that EMS coverage was unavailable. Interfacility transports, including behavioral transports, were identified as an area of concern for EMS agencies. Most survey respondents indicated that behavioral transports caused a strain on their EMS system.

The survey also sought information on the attitudes relating to the EMS education and certification process. Seventy-six percent of respondents thought that the time spent on EMS education was reasonable. The survey also requested provider attitudes on the cost and accessibility of EMS education and continuing education resources. Respondents provided a variety of ideas to help EMS provider retention efforts, including better pay, specifying EMS as an essential service, better pension and benefit options, state and local support in funding and planning, sustainable funding sources, provider education assistance, and better development of EMS career paths. Ninety-nine



percent of respondents believe that EMS should be an essential service. According to Mr. Ewers, EMS not being designated as an essential service has resulted in EMS being underfunded in order to preserve those services that have received such a designation.

Approximately 1/4 of respondents have out-of-pocket expenses of less than \$100 annually. Over 1/3 of the respondents also indicated that their out-of-pocket expenses are between \$100 and \$500 annually. In addition, approximately 1/4 of EMS providers have annual out-of-pocket expenses between \$500 and \$2,000.

The survey also detailed the compensation status of EMS providers, ranging from full compensation to no compensation. The average respondent spends 59.29 hours engaged in EMS training per year. Respondents receive an average of 44.36 hours of continuing education per year. The average survey respondent spends 23.23 hours per year raising funds for EMS. The average survey respondent spends 230 hours per year engaged as an EMS volunteer. Among respondents who work for volunteer EMS agencies, the average volunteer spends 30.56 hours fund-raising annually and dedicates 344.25 hours engaged as an EMS volunteer annually. Data was also presented on the trends in the number of EMS services and providers in the state over the last five years.

Mr. Ewers and Ms. Frederiksen also provided the written comments of EMS providers that were received as part of the survey.

IV. Emergency Medical Services Training Programs

Ms. Rosemary Adam, EMS Learning Resource Center, University of Iowa Hospitals and Clinics, and Ms. Tina Young, Southeastern Iowa Community College, provided the committee with information relating to the levels and types of training currently required for various levels of EMS providers. Iowa adopted national standards in 2011 for EMS providers. The initial educational requirements for the different levels of certification are: (1) emergency medical responder (EMR), 48-60 clock hours; (2) emergency medical technician (EMT), 150-190 clock hours; (3) advanced EMT, requiring a prerequisite EMT certification, 150-250 clock hours; and (4) paramedic, requiring a prerequisite EMT certification, 1,000-1,300 clock hours. Most educational programs have both part-time and full-time options. In terms of the number of weeks necessary to complete such courses, the EMR program typically takes 10 weeks part-time, the EMT program takes 34 weeks part-time or one month full-time, the advanced EMT program takes 40 weeks part-time, and the paramedic program takes two years part-time or 10-12 months full-time.

According to Ms. Adam, the initial costs of such education programs are as follows: (1) EMR, approximately \$400; (2) EMT, approximately \$1,030-\$1,800; (3) advanced EMT, approximately \$1,400 (following EMT prerequisite); and (4) paramedic, approximately \$6,171-\$12,000 (following EMT prerequisite). The estimated costs, however, do not include student fees, if applicable, or testing fees.

According to Ms. Adam and Ms. Young, the initial education for EMR, EMT, and advanced EMT can be offered in the provider's hometown, in a location such as the local fire department. The EMS Bureau is responsible for the authorization of training programs in the state. The 17 current EMS training programs are dispersed throughout Iowa, including one private college training program in Des Moines, two hospital-based training programs, and 14 community-college-based



Emergency Medical Services Study Committee

training programs. Eleven of the sites have paramedic education in the state and six sites have nonparamedic education.

The presenters also provided an overview of the continuing education requirements for the various EMS provider certifications. Such requirements include 50 percent formal classroom instruction and 50 percent informal instruction. The biennial hourly continuing education requirements are as follows: (1) EMR, 12 hours; (2) EMT, 24 hours; (3) advanced EMT, 36 hours; and (4) paramedic, 60 hours. There is a wide range of costs for formal continuing education courses, typically ranging from free to \$20 per hour. Most continuing education occurs in fire departments or ambulance services and each EMS training program offers formal continuing education courses.

Committee members questioned the current requirement that such training courses be approved and coordinated with one of the 17 approved EMS training programs. Ms. Adam and Ms. Young cited the need for structured and consistent quality assurance for the training and continuing education courses as the primary reason for requiring EMS training program approval for those courses conducted by persons other than the training programs. Committee members, however, continued to question the process of allowing the EMS training programs to establish the fees to be charged for such approved courses.

Ms. Adam detailed the 2012 enrollment and graduation data for each of the EMS certification levels in the state and described the enrollment trends in the state over the last 10 years. Areas of improvement for the EMS industry were also identified, including continued outreach to inform potential applicants in the EMS field, determining whether certain EMS provider positions should require a degree, and whether the return on investment is sufficient for those who enter the field.

Committee members inquired about the current reimbursement or financial assistance available for both initial certification and continuing education, including whether local governments reimbursed or paid for those costs, particularly for volunteers. Committee members also asked about the training programs' efforts to adapt the curriculum for military personnel who worked as combat medics. Ms. Adam indicated that because of the specific skills taught to the military combat medics and the need to teach the content covered by the national exam, the traditional training of such enrollees must be completed in its entirety.

V. Emergency Medical Services Reimbursement

Ms. Jennifer Vermeer, Director, Iowa Medicaid Enterprise, Iowa Department of Human Services, provided information to the committee relating to the reimbursement paid to ambulance providers for services provided to Medicaid members.

Medicaid managed care plans cover ambulance services through their contracts with ambulance providers. Medicaid pays a capitation payment to the managed care plan to cover all services included in the contract and the plan negotiates rates with providers. Ambulance services are provided through two contracted managed care providers, Magellan Behavioral Health (ambulance services relating to mental health or substance abuse conditions) and Meridian Health Plan (primary and preventive health care). Both managed care providers negotiate and contract with individual ambulance providers to form ambulance networks.



Medicaid contracts with and pays ambulance providers directly through Fee-For-Service (FFS) for members who require emergency medical transportation or transport because medical conditions preclude any other method of transportation. Reimbursement rates for such service are set by the Legislature's annual appropriations bill and a 10 percent increase was enacted for fiscal year 2013-2014. The Iowa Medicaid Enterprise conducts medical services and program integrity reviews.

IowaCare, the program which provides low income adults with limited health care benefits, does not cover ambulance services, but will be replaced by the Iowa Health and Wellness Program, which does cover ambulance services at the same rate as Medicaid. Medicaid providers must be enrolled as Medicare providers, have an EMS Bureau certification, sign a Medicaid provider agreement, make certain federally required disclosures, and have a verified ambulance compliance form. Ambulance programs are designated as moderate risk programs for fraud and require an Iowa Medicaid Enterprise site visit. Ms. Vermeer also provided examples of Medicaid reimbursement rates and stated that there is an interest in changing from the Medicaid reimbursement rates to the more complex Medicare reimbursement methodology. It was noted, however, that even the Medicare reimbursement does not cover the ambulance service costs in all instances.

Under the ambulance state plan for Medicaid, for the fiscal year 2012-2013, the total Medicaid expenditure was \$5.1 million, which included a total of 43,996 ambulance trips. The average number of trips per Medicaid member was approximately 2.5 trips.

VI. Public Comment and Committee Discussion, November 6, 2013

Committee members discussed whether the recent changes to the EMS certification levels and training requirements have pushed applicants into higher levels of training than what is necessary for the EMS that they are providing. Committee members raised concerns with the training availability in rural areas of Iowa and the lack of funding for reimbursement of training for EMS providers, particularly in the extremely rural areas.

Mr. Gary Merrill, Director, Algona Emergency Medical Service, opined that standards for EMS providers need to be high as they are medical providers who need to provide quality care and that background checks should be required. Mr. Merrill also stated his opposition to reducing the training requirements in order to recruit more EMS providers.

Mr. Jeff Burkett, a volunteer EMS provider from Prairie City, stated that identifying resources and complying with the requirements for obtaining grant moneys for training is confusing and time-consuming for smaller EMS agencies that are already time-constrained.

Mr. Jacob Mayer, a recently certified EMT from Lake City whose training was paid for by the hospital by which he is employed in exchange for a two-year employment commitment, stated that people need to understand that EMS providers are medical professionals and that training for such is going to cost money. Mr. Mayer also detailed his personal time commitment for performing his EMT duties as well as being a full-time community college student.

Dr. Scott Nelson, Director of Operations, Midwest Ambulance Services, opined that in adopting the national standards for the scope of practice for EMS providers, the ability to consider state and



Emergency Medical Services Study Committee

local needs in determining scope of practice was lost. In particular, Mr. Nelson identified the revisions to the scope of practice for critical care paramedics as a problem not just for the level of care provided to patients but also for reimbursement rates. Mr. Nelson also detailed his experience working in other states and how that experience has allowed him a better understanding of what is successful in providing EMS.

Committee members also questioned the EMS Bureau representatives about future plans to name a permanent EMS Bureau Chief and a state medical director. Iowa has been without a state medical director for 10 years and committee members questioned the rationale and impact that vacancy has had and what role EMSAC has played during that time. Members of the committee acknowledged that despite the lack of a state medical director, local EMS services are required to have a medical director who is a physician.

VII. EMS Provider Perspective

Mr. Brian Donaldson, Director, SEMS Paramedic Services, Sumner, Iowa, has worked in the EMS field for over 30 years. He discussed various issues relating to the EMS system in Iowa. Mr. Donaldson noted the difficulties faced by rural EMS providers and the lack of change in the EMS system design since its inception. Mr. Donaldson does not believe that the current design of the EMS system is supported by scientific evidence and that changes should be undertaken. He opined that consolidation, regionalization, and partnerships are key in regard to the future development of the EMS system, which should be led and supported by the state including the EMS Bureau. In particular, he noted that not every locality may require a transport ambulance service and that such service could be regionalized. Instead, he noted that the cost savings of investing in rapid response vehicles rather than ambulance vehicles could be substantial.

Mr. Donaldson also indicated that the approach to Medicaid reimbursement needs to be revised as Iowa has the lowest reimbursement rate in the upper Midwest and the fee schedule is not all-inclusive. Mr. Donaldson opined that there should be a mechanism in place for annual review of reimbursement rates. He also stated that behavioral health transport requirements and reimbursement need to be reevaluated. Such transports take EMS personnel out of service for a significant period of time and reimbursement does not follow the same Medicaid fee schedule.

Mr. Donaldson addressed the status of EMS and opined that EMS should be considered an essential service. Although townships and counties have the ability to tax for such services, no entity has the responsibility to provide service or funding. Mr. Donaldson noted that only Appanoose County is utilizing the one percent EMS income surtax. Committee members requested additional information in regard to the number of local governments that were currently imposing the maximum property tax levy. Mr. Donaldson also expressed his desire to see implementation of a Blue Ribbon Task Force to allow expert guidance from leaders in the industry for the creation of a plan to develop a sustainable system to provide quality care.

Mr. Donaldson also addressed the possible use of EMS providers to provide follow-up services to patients recently discharged from hospitals in order to reduce the likelihood of being readmitted to the hospital and consequently impacting the hospital's reimbursement. Committee members asked Mr. Donaldson to identify examples of these types of services and questioned whether such services would encroach on home health care providers. Mr. Donaldson noted that only about five



percent of services provided are life-threatening emergencies and EMS should be viewed instead as mobile health care.

In response to committee questioning, Mr. Donaldson stated his uncertainty about whether existing recruitment efforts are successful and urged the further easing of the financial burden on EMS providers, including an increase in the existing \$50 income tax credit. Committee members also discussed the use of local law enforcement in behavioral transport cases.

VIII. EMS Advisory Council, Quality Assurance, Standards and Protocols Subcommittee

Mr. Gerd Clabaugh, Deputy Director, Iowa Department of Public Health, discussed the Quality Assurance, Standards and Protocols (QASP) Subcommittee's review of the administrative rules governing the authorization of EMS service programs. The subcommittee has several areas to focus on in its review, which began in August 2013: the authorization levels for service programs, medical director training requirements, continuous quality improvement, data-related issues, and disciplinary procedures. According to Mr. Clabaugh, the goal at the end of the review process is to have the Department of Public Health synthesize the feedback and recommendations and then present the proposed changes to EMSAC again.

The presenters noted the overall concern that the administrative rules have not remained current with practices of the EMS industry. However, specific issues were addressed by Mr. Clabaugh including simplifying authorizations, providing the ability for EMS providers to perform tasks at different levels, revision and improvement of medical director training and transition, and addressing the frequency of inspections.

Ms. Frederiksen acknowledged the importance of the data being collected by the EMS Bureau for both the bureau and the EMS services. EMS services utilize the data to improve their services and increase efficiencies. Ms. Frederiksen noted, however, that the EMS Bureau's data collection system is 10 years old and may need revision.

Mr. Clabaugh identified system development grants as a possible source of funding to help facilitate regionalization of EMS in the state. The subcommittee representatives also addressed committee questions relating to the implementation of proposals relating to the use of paramedicine and the use of transportation methods other than ambulances. Committee members also questioned the current practice of requiring training centers to serve as clearinghouses for EMS training being provided in the state.

IX. Public Comment and Committee Discussion, November 7, 2013

The co-chairs opened the meeting for public comment and several EMS providers made remarks to the committee.

Mr. Orville Randolph, the mayor of Bennett and the director of the city's volunteer ambulance service, discussed the financial and other concerns of smaller volunteer services like Bennett's, including problems finding daytime coverage with volunteers who have full-time jobs, the dwindling funds for EMS System Development Grants, and the high turnover rate for service directors. Mr. Randolph provided details of his community's EMS system. He also stated that his city is already



Emergency Medical Services Study Committee

at its \$8.10 levy limit and that grant money has decreased in recent years. He identified the existing income tax credit as a positive move but asked if it could be increased. Cost-saving measures, such as sharing local medical directors, were discussed. Mr. Randolph acknowledged the good work provided by the EMS Bureau but identified the reduced EMS Bureau staffing as a problem.

Committee members had further discussions on the issues of background checks, what an EMS mandate to local governments would include, the long-term consequences of reduced staffing at the EMS Bureau, the use of law enforcement officers as EMRs, the role of the EMS Bureau in facilitating solutions, and the trend of increased EMS call response times.

Co-chairperson Wilhelm requested the members of the committee to each discuss a few issues that they felt should be addressed. Several members commented that EMS should be made an essential service just as law enforcement and fire service are, but that how such service is paid for also needs to be addressed. Other issues raised included behavioral health transport requirements and reimbursement; providing funding for EMS provider training, possibly through the community colleges; requiring background checks; increasing the income tax credit for volunteer providers; establishing a Blue Ribbon Task Force to further study the EMS system; increasing Medicaid reimbursements; increasing funding for and staffing of the EMS Bureau, including the addition of a State Medical Director; incentivizing the transition from EMT to paramedic; and determining whether personal medical information in data should be collected or retained.

X. Materials Filed With the Legislative Services Agency

The following materials were distributed at or in connection with the meeting and are filed with the Legislative Services Agency. The materials may be accessed from the “Committee Documents” link on the committee’s Internet site:

<https://www.legis.iowa.gov/Schedules/committee.aspx?GA=85&CID=929>

1. EMS Bureau Presentation — Materials Provided Subsequent to Meeting
2. Mr. Brian Donaldson, SEMS Paramedic Services, Presentation
3. Iowa EMS Association Presentation — Additional Materials
4. Iowa EMS Association Presentation
5. EMS Training Programs Presentation
6. Attachment A: Authorized EMS Agencies (2013) map
7. Attachment B — Authorized Iowa EMS Agencies List
8. Attachment C: Iowa Emergency Medical Care Provider Scope of Practice (April 2012)
9. Attachment D — Authorized Iowa EMS Training Programs (July 2013)
10. Attachment E — Property Tax Rates for Fire and Emergency Medical Services (FY 2014)
11. Attachment F — Emergency Medical Services System Development Grants FY 2012-2014
12. Attachment G — EMS Response Times Per County, EMS Bureau Data



13. Attachment H — EMS Service Level Response Times, EMS Bureau Data
14. Background Information, Legislative Services Agency
15. Legislative Services Agency, Fiscal Services Division, Background Information on EMS Services in Iowa
16. DHS Medicaid Presentation
17. EMS Bureau Quality Assurance, Standards, and Protocols Subcommittee, Document 1
18. EMS Bureau Quality Assurance, Standards, and Protocols Subcommittee, Document 2

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